

Date: August 9, 2005

ELDERKIN, MARTIN, KELLY & MESSINA 150 East Eighth Street, Erie, Pennsylvania 16501 (814) 456-4000 FAX (814) 454-7411

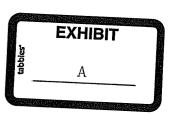
FACSIMILE TRANSMITTAL SHEET

Submitted by:								
J. T. Messina	J. B. Enders	G. T. Nietupski	C. J. Kovski	L. S. Nelson				
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J. H. Richardson, Jr.	C. A. Markham	E. J. Betza	L. R. Miller	Of Counsel				
R. L. Slater	T. J. Minarcik	C. A. Zonna	M. H. Shirey					
PLEASE DELIVER THE FOLLOWING PAGES TO:								
NAME:	Marcus Chatwood							
COMPANY/FIRM:	Jefferson Pilot Financial							
FAX NUMBER:	800-259-233	35						
Total number of Pages, including this page: 5								
COMMENTS:								

If you do not receive a legible copy of all pages, please call (814)456-4000 immediately.

NOTICE: The information contained in this facsimile message is attorney-client privileged and/or confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.

EMKM File No.: 25229.001



Time: 3:05 p.M.



Jefferson Pilot Financial Insurance Company, PO Box 2616, Omaha, NE 68103-2616 Phone (877) 843-3948 Fax (877) 843-3950

AUTHORIZATION FOR RELEASE OF DISABILITY AND LIFE INFORMATION

L.	I (the undersigned) authoriz	e Jefferson Pilot Financial I	nsurance Company ("Compa			
	Claimant/Patient Name:	Laymon	Larry		L.	
	Date of Birth: 2-20-41	(Last)	(First) er/Social Security Number:	•	ddle) 318	
	Date of Birth:	Con Amonday A at	ttached hereto			
2.	Information to be released:	See Appendix A a	ctached hereto.			
3.	Information to be released t	o:Laura Steehle	r Nelson, Esquire			
		(Name of individual or c	ompany authorized to receiv	e information) call		
	透 Telephone <u>814</u> - Include Area C	456 - 4000 Code and Phone number		call	am/pm	
	Address 150 East E	Eighth Street	Erie	PA	16501	
	(Street/PO Box)		(City)	(State)	(Zip)	
4.	I understand the informatio purpose of <u>Laymon v.</u>	n obtained by use of this A Canada Life Assur	Authorization will be used by cance Company	Atty. Nels	son for the	
	It will be subject to the follo					
5.	I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law.					
6.	I understand that I may revoke this Authorization in writing at anytime. To initiate revocation of this Authorization, direct a correspondence to the Company at the above address. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below.					
7.	A photocopy of this Authoriz	zation is to be considered a	as valid as the original.			
8.	I understand I am entitled to	o receive a copy of this Aut	horization.	8/8/0	_	
min	MATURE: imant/legal representative (Mator, legally incompetent, or decomposition) NT NAME: ARR	ceased) Power of attorney	lan, or appointed representa or guardianship must be att	tive to sign only	if claimant/patient is a	
Rel	ationship to Claimant/Patient	of personal/legal represe	ntative signing for Claimant/	Patient:		
ADI	ORESS: 3063 West 11 (Street/PO Box)	th Street, Apt. 25	5 Erie (City)	PA (State)	16505 (Zip Code)	
TEL	EPHONE: 814 - 835 Include Area Code a					

APPENDIX A

(continued from Jefferson Pilot Financial Insurance Company, "Authorization for Release of Disability and Life Information")

Question 2. Information to be Released

- 1) All documents and/or information concerning or relating to Larry Laymon, including but not limited to, those documents concerning or relating to Larry Laymon's claims for short-term disability and long-term disability.
- 2) All documents used and/or considered in the denial of Larry Laymon's long-term disability claim.
- 3) All documents requested and/or referred to in the attached "Authorization for Use and Disclosure of Health Information."

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:

Larry L. Laymon

Date of Birth: 02/20/1941

Address:

3063 West 11th Street; Apt 25

Erie, PA 16505

Social Security Number:

280-36-7818

I authorize the disclosure by Jefferson Financial Insurance Company (formerly known as Canada Life Assurance Company) to the law firm of **ELDERKIN**, **MARTIN**, **KELLY & MESSINA**, or any representative thereof, the portions of my health information or records set forth below and to respond to requests for their opinion regarding my physical or mental condition, including but not limited to opinions regarding my history, prior medical history, findings, interpretation of diagnostic tests or lab results, diagnosis, etiology of my condition, reasonableness and necessity of treatment, need for future treatment (including the nature, frequency and usual and customary charge for such treatment), prognosis and physical limitations (including any disability, impairment or handicap).

The health information that I authorize to be disclosed to the law firm of **ELDERKIN**, **MARTIN**, **KELLY & MESSINA**, or any representative thereof, is:

- Entire hospital chart, including but not limited to problem list, medication list, admission sheet, history and physical, discharge summary, laboratory results, progress notes, nurse's notes, emergency room records, x-ray and imaging studies, toxicology screens, consultation reports, operative reports, anesthesia records, labor and delivery records, progress records and attending physician notes and reports.
- Pharmacy or prescription records.
- Mental health records, including records from any psychiatrist, psychologist, social worker or other licensed mental health professional or their staff.
- Entire chart of any physician or group of physicians whether operating as a sole proprietorship, partnership or corporation, including records supplied to the physician or member of the group from any other medical provider, hospital, emergency room, psychiatrist, psychologist, attorney, insurer or other third party other than the physician or member of the group.
- All diagnostic tests or imaging studies, including but not limited to x-rays, MRI's, EMG's, ENG's, EEG's, EKG's, discograms, CAT scans, PET scans, arthrograms, myelograms, diagnostic arthroscopies, ultrasounds, and Doppler studies, including both the report of the study and the study itself.
- Entire chart of any physical or occupational therapist or physical or occupational therapy group including records supplied to the physical therapist, occupational therapist or physical or occupational therapy group by a physician not a member of the group, a referring physician, or from any other medical provider, hospital, emergency room, psychiatrist or psychologist, attorney, insurer or other third party other than the therapist or member of the physical or occupational therapy group providing the therapy.

- Entire chart of any chiropractor or group providing chiropractic treatment or services including records contained in the chart received from persons or entities other than the chiropractor or group providing the treatment or services.
- Records of any EMS, BLS or ALS group or unit providing medical care, including the records of any private or public ambulance company or unit.
- Itemized billing statements for all medical services rendered.

The law firm of **ELDERKIN**, **MARTIN**, **KELLY & MESSINA** has been retained by me to investigate, and if warranted pursue to a conclusion, a legal matter in which I am involved. Therefore, your full cooperation with them is respectfully requested.

You are further directed to disclose no information to any insurance adjuster or other persons or entities without written authority from me to do so (pursuant to privilege and confidential communication laws, including but not limited to the provisions of the HIPAA) with the exception of persons, insurers or entities from whom you receive a written authorization signed by me that is in compliance with Section 164.508 of HIPAA.

I understand that the information in my health record may include information relating to sexually transmitted disease, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing specifically directed to you, and that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this Authorization. I also understand that I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information about me carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition:

08/08/2006	
A REPRODUCED COPY OF THIS AUTHORIZATION	N SHALL BE AS VALID AS THE ORIGINAL
Say Saymor	08/08/05
Signature of Patient or Legal Representative	Date
	Lana Stroken Mohan
If signed by Legal Representative, Relationship to Patient	Signature of Witness